

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15428 CERTIFICATE OF DEATH 15427									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural White Hall				c. LENGTH OF STAY IN JB 37 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural White Hall			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shawsville					d. STREET ADDRESS Shawsville			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NOLA RAY ADAMS					4. DATE OF DEATH Month Day Year Nov. 16 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/19/1909		9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lester W. Copenhaver					14. MOTHER'S MAIDEN NAME Viola Grimm				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-38-8289		17. INFORMANT C. Merediethe Adams			Address Parkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								21120 INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1950 to Nov. 16, 1967 , that (I) (we) last saw the deceased alive on Nov. 15 1967 , and that death occurred at 5:30 M, from the causes and on the date stated above.									
22a. SIGNATURE A.M. France								22b. DATE SIGNED 11/16/1967	
22c. PHYSICIAN'S NAME (Type) A.M. FRANCE				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS PARKTON, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/18/1967		23c. NAME OF CEMETERY OR CREMATORY Bethel			23d. LOCATION (City, town or county) (State) Madonna, Maryland	
24. FUNERAL DIRECTOR Charles E. Kurtz					ADDRESS Jarrettsville, Md.		25a. REC'D BY REGISTRAR NOV 20 1967		
							25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

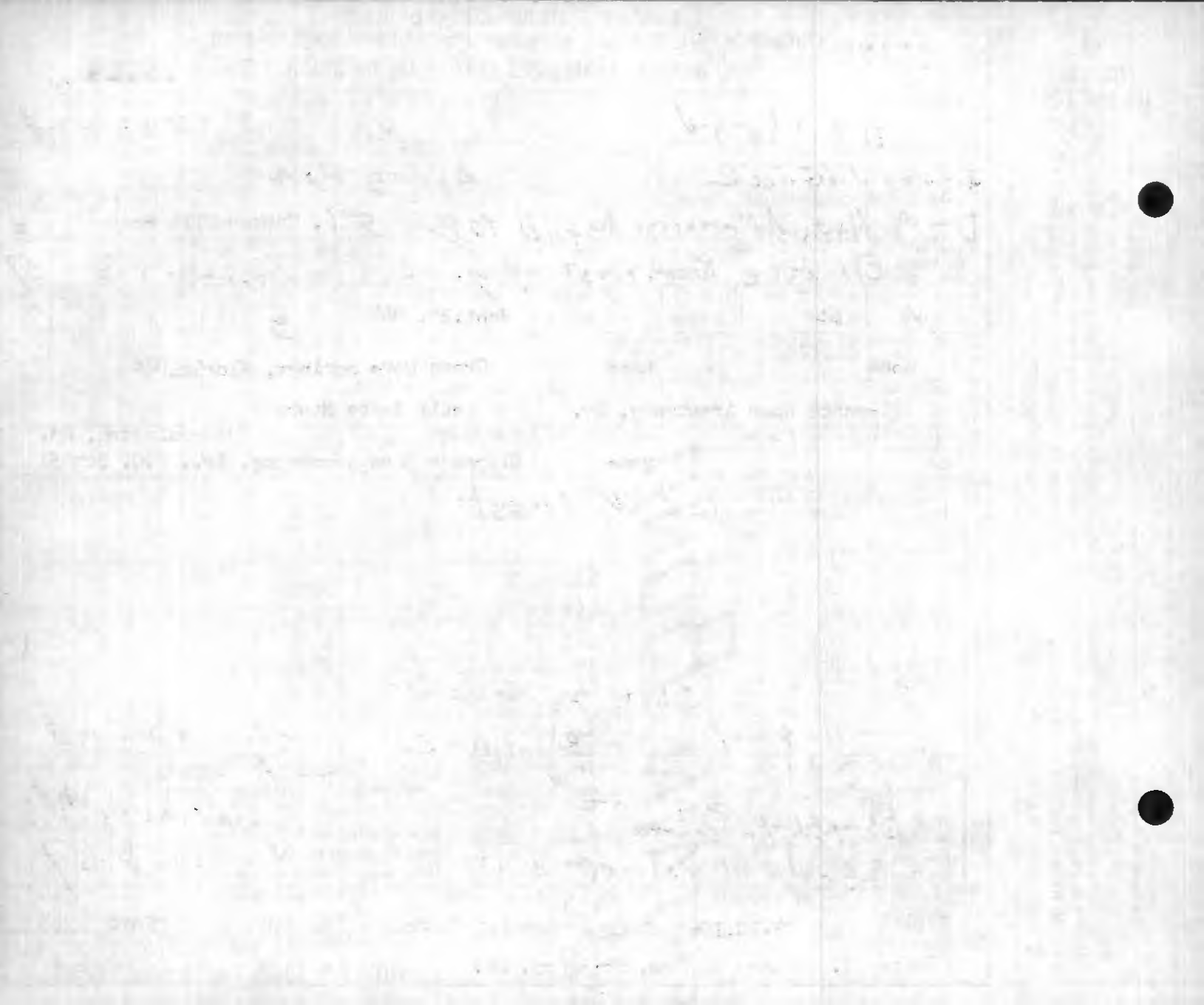
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15428

15428

1. PLACE OF DEATH a. COUNTY <u>Hd 2-fo-2-d</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Do A Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Po Box 51, Hooker Mill Road</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence Ross Armstrong, Jr.</u>		4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1964</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Green Cove Springs, Florida USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Clarence Ross Armstrong, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Betty Joyce Moore</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Clarence Ross Armstrong, Sr., P.O. Box 51</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>9190</u> IMMEDIATE CAUSE (a) <u>GSW chest</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>Shot by Sister</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> p.m. <u>11-8-67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Abingdon Hd Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL EXAMINER'S NAME (Type) <u>Gerald P Palmer</u>		22. DATE SIGNED <u>11-8-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 10, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



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VR A15 (4)
20 M 1/66

15430

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15429

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN lb <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>RURAL-COLORA</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth F</u> First <u>Baughman</u> Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE (In years last birthday) <u>70</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Fogus</u>		14. MOTHER'S MAIDEN NAME <u>MINERVA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-01-79630</u>	
17. INFORMANT <u>Ralph Baughman, Harre de Grace, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Anterior Myocardial Infarction</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>A.S. C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>2-3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm + Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>67</u> , to <u>11-26</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-26</u> , 19 <u>67</u> , and that death occurred at <u>6:05</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/26/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre de Grace, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/30/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WEST NOTTINGHAM CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>COLORA CECIL MD</u>
24. FUNERAL DIRECTOR <u>RALPH M REED</u> ADDRESS <u>RISING SUN, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

2262

STATE OF TEXAS

1882

THE COMMISSIONER OF THE GENERAL LAND OFFICE

STATE OF TEXAS

TO THE HONORABLE THE COMMISSIONER OF THE GENERAL LAND OFFICE

STATE OF TEXAS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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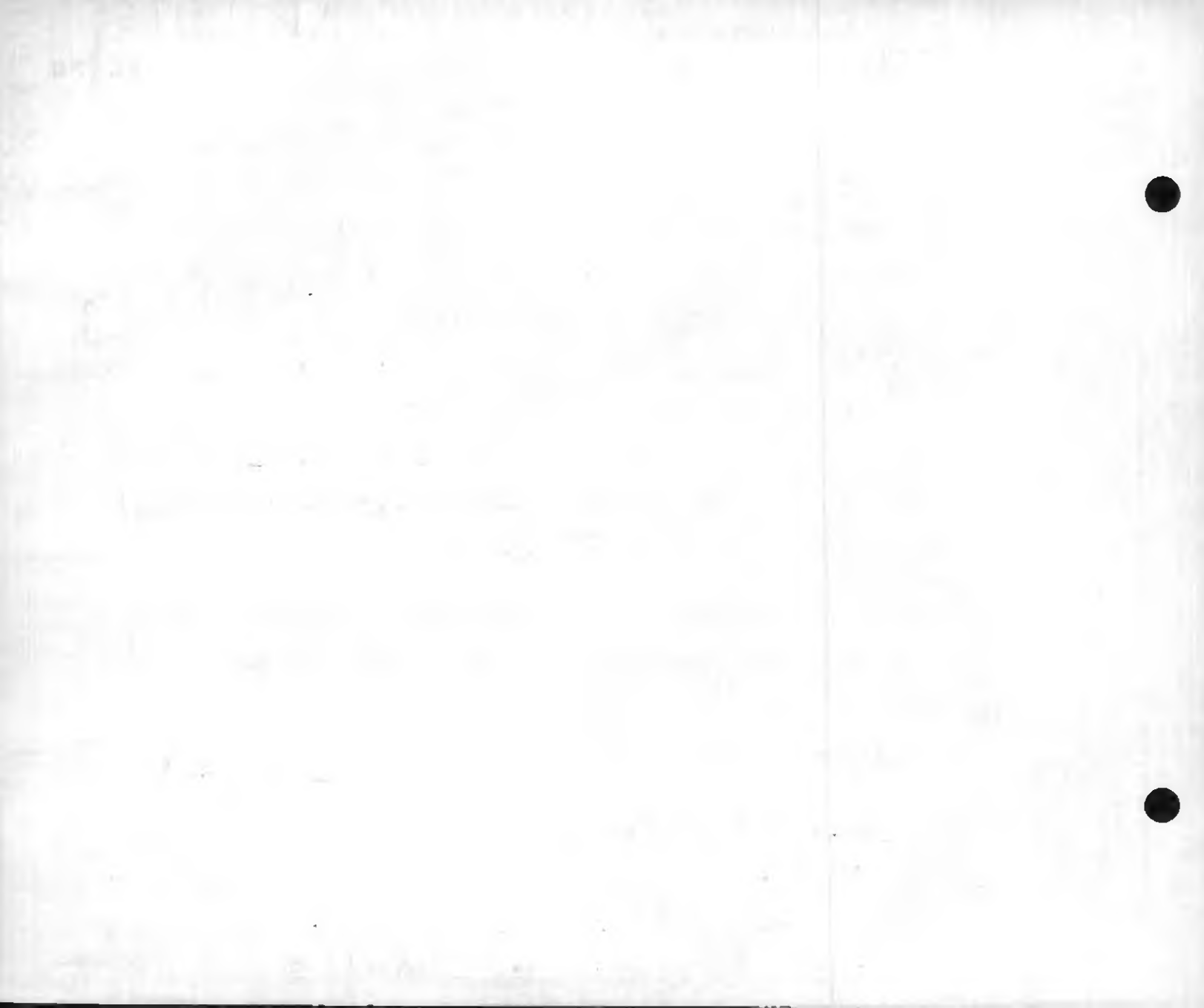
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15430

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa - Rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa - Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none				d. STREET ADDRESS Box 412, Dembytown Road			
3. NAME OF DECEASED (Type or print) First ROBERT Middle C. Last BOND, JR.				4. DATE OF DEATH Month NOVEMBER Day 12 Year 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1967		9. AGE (In years last birthday) yrs. 1	IF UNDER 24 HRS. Months 1 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert C. Bond, Sr.				14. MOTHER'S MAIDEN NAME Gloria Elder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert C. Bond, Sr. Box 412, Dembytown Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7562 Congenital Malformation, intestinal IMMEDIATE CAUSE (a) Tract. S.D.I.I. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 						INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gerald C. Palmer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gerald C. Palmer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) Bel Air, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Benezer Baptist Cemetery		23d. LOCATION (City or Town) (County) (State) Joppa Harford Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR NOV 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



15432

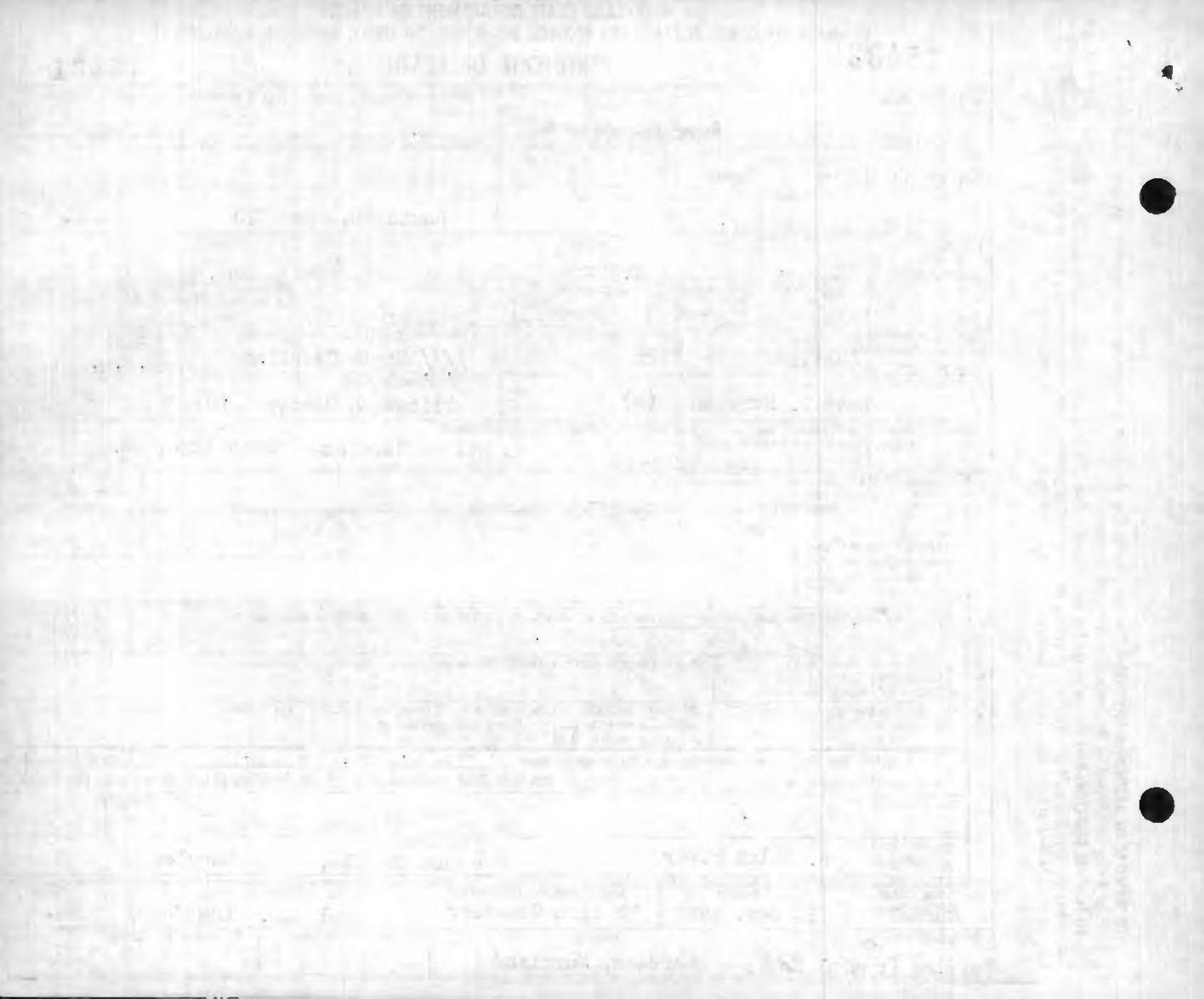
CERTIFICATE OF DEATH

15431

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		d. STREET ADDRESS <u>Route #2, Box 278</u>	
3. NAME OF DECEASED (Type or print) <u>George Arthur Burcham</u>		4. DATE OF DEATH <u>Nov. 15 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-1880</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi D. Burcham (D)</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gentry (D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-3662</u>	
17. INFORMANT <u>R. Walter Burcham,</u> Address <u>Conowingo, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia Hypertrophy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1967</u> to <u>Nov 15, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Nov 15, 1967</u> , and that death occurred at <u>2 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>J. Ralph Horky</u>		22b. DATE SIGNED <u>11/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horky</u>		22d. ADDRESS <u>Churchville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>18 Nov. 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, (Harford) Md.</u>
24. FUNERAL DIRECTOR <u>Louise B. Borge</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



CERTIFICATE OF DEATH

15132

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first after Residence before admission) a STATE <u>MD</u> b COUNTY <u>Hartford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harce de Grace</u>		c LENGTH OF STAY IN 1b <u>DOA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>		d STREET ADDRESS <u>977 Chesapeake Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Vernon M. Burns</u>		4 DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/27/1902</u>
9 AGE (in years last birthday) <u>65</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Club</u>		10b KIND OF BUSINESS OR INDUSTRY <u>State Store</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Harce de Grace, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13 FATHER'S NAME <u>Charles B. Burns</u>		14 MOTHER'S MAIDEN NAME <u>Ellen Ellen Burns</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk.</u>		16 SOCIAL SECURITY NO. <u>unk.</u>	
17 INFORMANT <u>Elena E. Burns</u>		18 ADDRESS OF INFORMANT <u>977 Chesapeake Blvd Harce de Grace MD</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerosis</u> DUE TO (c) <u>hypertension</u>			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>67</u> , to <u>11/21</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11/21</u> , 19 <u>67</u> , and that death occurred at <u>7:12</u> P.M., from causes and on the date stated above.			
22a SIGNATURE <u>E. J. Burns</u>		22b. DATE SIGNED <u>11/21/67</u>	
22c PHYSICIAN'S NAME (Type) <u>E. J. Burns</u>		22d. ADDRESS <u>Hartford</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11/25/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	23d LOCATION (City or Town) (County) (State) <u>Harce de Grace Md.</u>
24. FUNERAL DIRECTOR <u>Frederick R. Harce de Grace, Md.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 27 1967</u>	25b REGISTRAR'S SIGNATURE <u> </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DIRECTOR MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MA</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. LENGTH OF STAY IN TB <u>D.O.A. - 7:10 P.M.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>128 South Philadelphia Blvd.</u>	
3 NAME OF DECEASED (Type or print) <u>William Edward Calder</u>		4 DATE OF DEATH <u>November 5 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>October 12, 1937</u> 9 AGE (In years lost birthday) <u>30</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rubber-Plastic</u>	
11 BIRTHPLACE (State or foreign country) <u>Hartford Co., Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William E. Calder</u>		14 MOTHER'S MAIDEN NAME <u>Hazel Wildason</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Oct. 54 - Nov. 62</u>		16 SOCIAL SECURITY NO. <u>213-30-7120</u>	
17 INFORMANT (Mother) <u>838-6376</u> Address <u>Mrs. Hazel W. Wells 1101 Baltimore Pike Bel Air, Maryland 21014</u>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART IIc.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, all care bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Injury <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald P Palmer M.D.</u>		Address (Street, city, town, or county) <u>Bel Air - MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____
24 FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>		25a. REC'D BY REG. STRAR <u>NOV 8 1967</u> 25b. REG. STRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

15135

11-23

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe de Grace</u>		c. LENGTH OF STAY in <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		d. STREET ADDRESS <u>Street</u>	
3 NAME OF DECEASED (Type or print) <u>Leo Carr</u>		4 DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>SEPT. 3, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>76</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Street, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse Carr</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Cunningham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>219-12-7499</u>	
17. INFORMANT <u>EMMETT CARR, DARLINGTON, MD.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Compensative Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Passive Congestive Heart Failure</u> DUE TO (c) <u>Anticoagulant Therapy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anticoagulant therapy, extensive</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-11, 1967</u> to <u>11-23, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-23, 1967</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ralph Horky</u>		22b. DATE SIGNED <u>11/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. RALPH HORKY MD</u>		22d. ADDRESS <u>CHURCHVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SOUTHERN</u>	23d. LOCATION (City or Town) (County) (State) <u>DUBLIN, HARFORD, MD.</u>
24. FUNERAL DIRECTOR <u>John H. Haskins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>NOV 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15435

CERTIFICATE OF DEATH

15435

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c LENGTH OF STAY IN 1b <u>1/12 to 11/29/67</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret A. Chandlee</u>		4. DATE OF DEATH Month Day Year <u>Nov. 29 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>01/31/77</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Lapedum, Md.</u>	11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>
13 FATHER'S NAME <u>Wm C Knight</u>		14 MOTHER'S M A DEN NAME <u>Mary Daugherty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-22-1501</u>	
17 INFORMANT <u>Jim Chandler</u>		Address <u>Darlington, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>And a series of small strokes</u> DUE TO (c) <u>over past 2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>67</u> , to <u>Nov 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 27</u> , 19 <u>67</u> , and that death occurred at <u>12</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips MD</u>		22b. DATE SIGNED <u>12/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>Darlington Md 21034</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darlington</u>	23d. LOCATION (City or Town) (County) (State) <u>Darlington Md</u>
24. FUNERAL DIRECTOR <u>Harry P. P. Harre de Grace Md</u>		25a REC'D BY REGISTRAR <u>DEC 5 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

25137

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>	
d. LENGTH OF STAY IN 1b <u>22 yrs.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>322 So. Union Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Patrick Cunningham</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/27/1927</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov.</u>		11 BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>	
13 FATHER'S NAME <u>Roger C. Cunningham</u>		14 MOTHER'S MAIDEN NAME <u>Madeline Stibley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Ylanda M. Cunningham</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombosis of the coronary artery</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12</u> , 19 <u>67</u> , to <u>Nov. 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 12</u> , 19 <u>67</u> , and that death occurred at <u>1:50</u> M., from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Harford Grace, Md.</u>
24 FUNERAL DIRECTOR <u>Funeral Home, Harford Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH

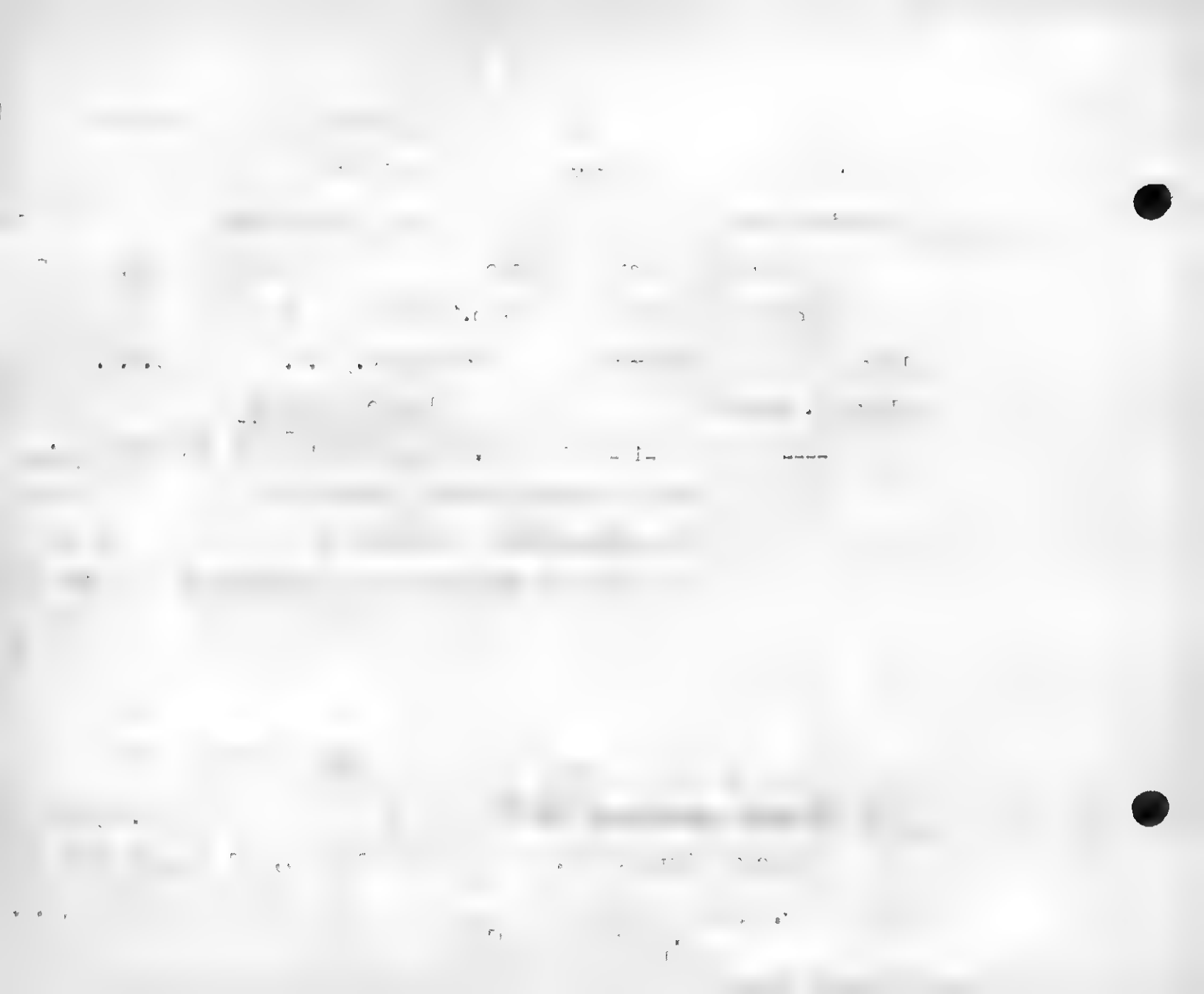
15433

15437

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 325 Choice Street		d. STREET ADDRESS 325 Choice Street	
3 NAME OF DECEASED (Type or print) Raymond Stuart DeVane		4 DATE OF DEATH November 12, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 14, 1876
9 AGE (In years lost birthday) 91 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		12 C. KIND OF BUSINESS OR INDUSTRY Hardware	
13 FATHER'S NAME William T. DeVane		14 MOTHER'S MAIDEN NAME Elizabeth Newkirk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 239-10-4240	
17. INFORMANT Daughter 838-5415		Address 325 Choice St. Bel Air, Md. 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221 ACUTE CARDIO-RESP. FAILURE DUE TO (b) PULMONARY EDEMA DUE TO (c) ADVANCED CARDIO-VASC. SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 1 HR 2 HRS 6 MONTHS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MED. CAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 to 12 Nov , 1967, that (I) (we) last saw the deceased alive on 12 Nov , 1967, and that death occurred at 6:45 A M, from causes and on the date stated above.			
22a SIGNATURE H. Proctor Sidwell M.D.		22b. DATE SIGNED Nov. 12, 1967	
22c. PHYSICIAN'S NAME (Type) H. Proctor Sidwell, M.D.		22d ADDRESS 401 Franklin St., Bel Air, Md. 21014	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY LaFayette Memorial Park	23d. LOCATION (City or Town) (County) (State) Fayetteville, Cumberland, N.C.
24 FUNERAL DIRECTOR W. Broadway & Williams		25a REC'D BY REGISTRAR NOV 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

15438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERGUE GRACE</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. STREET ADDRESS <u>112 So Reed St.</u>	
3 NAME OF DECEASED (Type or print) <u>Harold</u> First <u>Kenneth</u> Middle <u>Ditzenberger</u> Last		4 DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 5, 1921</u>
9 AGE (In years last birthday) <u>46</u> yrs		10 IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Standard Lab. Tech.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics-Chemical</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Lebanon, Indiana</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Otto S. Ditzenberger</u>		14 MOTHER'S MAIDEN NAME <u>Vesta May Morris</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW2</u>		16 SOCIAL SECURITY NO <u>314-12-4970</u>	
17 INFORMANT (Name) <u>Mrs. Caroline B. Ditzenberger</u>		Address <u>112 S. REED ST. BEL AIR, MD. 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia and irreversible renal damage</u> DUE TO <u>acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>chronic nephritis</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>cardiac decompensation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>poss. 2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal Hypertension + Cardiac decompensation</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-21</u> , 19 <u>67</u> , to <u>11-6</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11-6</u> , 19 <u>67</u> , and that death occurred at <u>10:45</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/6/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haure de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford Co., Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1967</u>	
ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

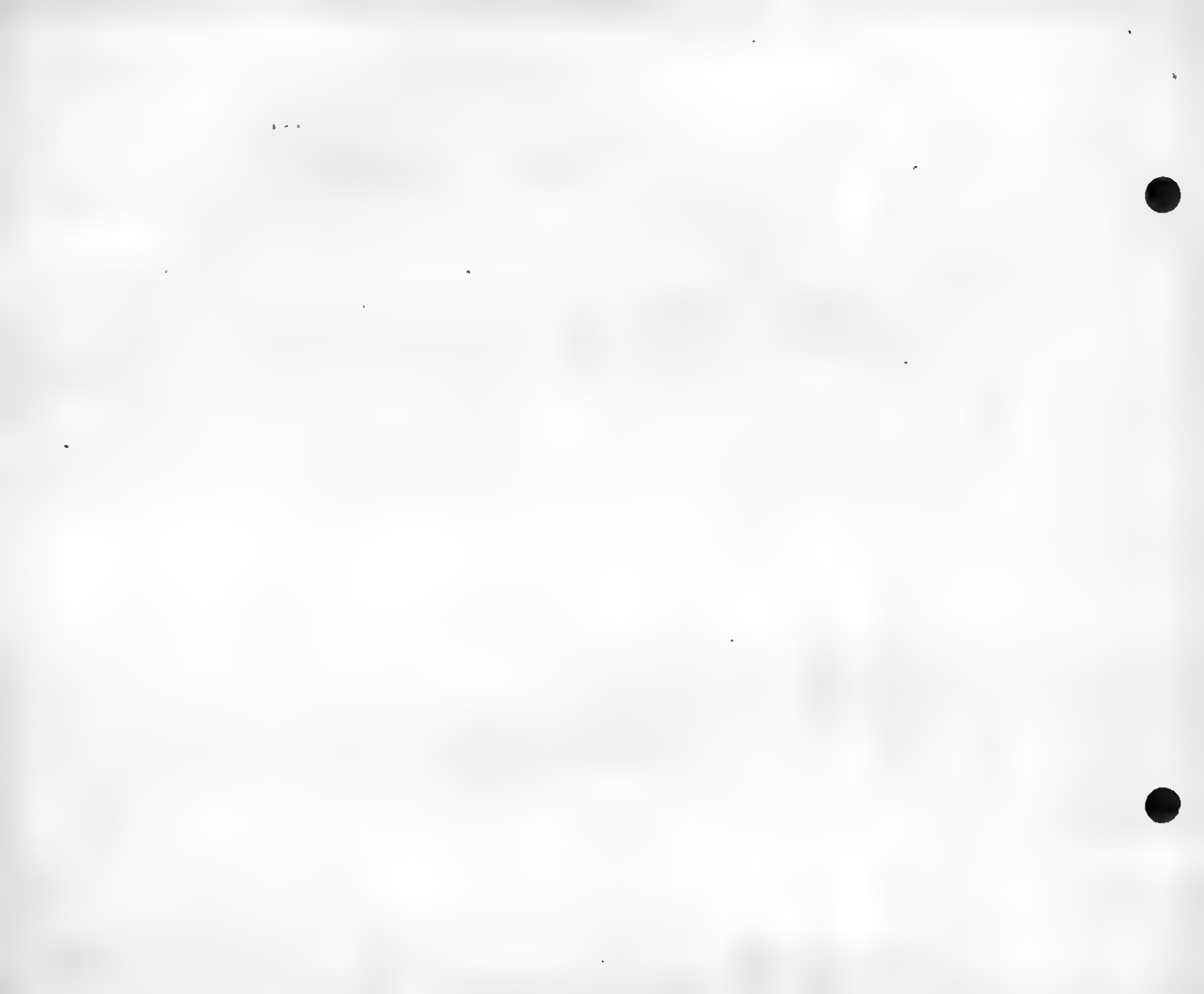
1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fawn Grove (rural) c. LENGTH OF STAY IN 15 1 month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Onion Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville d. STREET ADDRESS Salem Church Road							
3. NAME OF DECEASED (Type or print) William Martin Emrick				4. DATE OF DEATH November 15, 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1878		9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Gen. farming		11. BIRTHPLACE (County & State, or foreign country) Jarrettsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Emrick				14. MOTHER'S MAIDEN NAME Mary Bahr							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-46-0034				17. INFORMANT Mrs. Mary C. Onion			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, myocardial failure DUE TO (b) Diabetes mellitus, chr. prostatic DUE TO (c) Obstruction and old age.				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tractor accident -3 months previous.				19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 8, 1967 to Nov. 16, 1967 that (I) (we) last saw the deceased alive on Nov. 16, 1967 and that death occurred at 5:30P from the causes and on the date stated above.											
22a. SIGNATURE Norman H. Gemmill						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 11/16/67		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Norman H. Gemmill, M.D.						22d. ADDRESS Stewartstown, Pa. 17363					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/18/1967		23c. NAME OF CEMETERY OR CREMATORY Fawn Grove Methodist		23d. LOCATION (City, town or county) Fawn Grove, Pa.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz						ADDRESS Jarrettsville, Md.		25a. REC'D BY REGISTRAR NOV 17 1967		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY Harford		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland...		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN TB 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Citizens Nursing Home		d. STREET ADDRESS Route #3, Box 285		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) GLADYS		First S.		Middle FLESHMAN	
4 DATE OF DEATH Month November 30,		Day 1967		Year 1967	
5 SEX x Female		6 CO. OR OR RACE Caucasian		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH April 27, 1900		9 AGE (in years last birthday) 67		10 F UNDER 1 YEAR Months Days Hours Min.	
11 BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13 FATHER'S NAME George L. Rand		14 MOTHER'S MAIDEN NAME Unknown			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213-28-3904		17 INFORMANT Raymond E. Wright, Woodhaven, N.Y. 11421	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus ; Arteriosclerotic Heart Disease		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 3-22- 19 56 , to 11-30- 19 67 , that (I) (we) last saw the deceased alive on 11-30- 19 67 , and that death occurred at 4:00pm , from causes and on the date stated above.					
22a. SIGNATURE Peter P. Rodman		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12-1-67	
22c. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.		22d. ADDRESS 8 Law Street, Aberdeen, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4 Dec. 1967		23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery	
23d. LOCATION (City or Town) Perryman, (Harford) Maryland		23e. REC'D BY REGISTRAR DATE DEC 4 1967		23f. REGISTRAR'S SIGNATURE Charles J. George	



CERTIFICATE OF DEATH

15142

41

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Hartford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hartford Memorial Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Hartford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS 305 Wakefield Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eloise Naomi Gibbs				4 DATE OF DEATH November 22 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 15, 1909	9 AGE (n years last birthday) 58 yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (County & State, or foreign country) East Springfield, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOVELL D. HAMMOND				14. MOTHER'S MAIDEN NAME CLARA L. STEARNS			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 292-07-1264		17 INFORMANT (Husband) 838-7158 Address 305 Wakefield Drive Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO (b) Anteroseptal myocardial infarction DUE TO (c) A.S. C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus - 7 years						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11/21 1967 , to 11/23 1967 that (I) (we) lost saw the deceased alive on 11/22 1967 , and that death occurred at 12 A.M. from causes and on the date stated above.							
22a. SIGNATURE Edward C. Loo, M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/23/67		
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.			22d. ADDRESS Havre de Grace, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 28, 1967		23c. NAME OF CEMETERY OR CREMATORY LA CARPE Cemetery		23d. LOCATION (City or town) (County) (State) LA CARPE, OTTAWA Co. Ohio	
24. FUNERAL DIRECTOR JOSEPH WILLIAM FOSTER ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			25a. REC'D BY REGISTRAR NOV 27 1967		25b. REGISTRAR'S SIGNATURE Francis Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item #18 & 20a-20f Item #395 12-6-67 mt MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15442 15443 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN 1b D.A.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a. STATE Maryland b. COUNTY 11 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS RD 2, Box 114 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CARVILLE GARRITTE TAYLOR GILBERT Middle Last 4. DATE OF DEATH November 17, 1967 Month Day Year						5. SEX Male 6. CO. OR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH OCT. 11, 1892 9. AGE (In years last birthday) 75 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min					
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MD		12. CIT ZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MARTIN LEE GILBERT						14. MOTHER'S MAIDEN NAME LUCY VIRGINIA HUGHES					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO 212-26-6334		17. INFORMANT Mr. AMOS H. HARLAN Address Havre de Grace, Md.					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of Aorta 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) river went around curve, kept in wrong lane & hit another car head-on.							
20c. TIME OF INJURY Month, Day, Year 6:45 p.m. 11-17 1967				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Aberdeen (County) Harford (State) Md			
21. I certify that I took charge of the removals described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)					
22. DATE SIGNED 11/18/67											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF Nov. 20, 1967		23c. NAME OF CEMETERY OR CREMATORY WESLEYAN CHAPEL CEM. HARFORD		23d. LOCATION (City or Town) (County) (State) Co MD			
24. FUNERAL DIRECTOR R. Madison Mitchell ADDRESS HAVRE DE GRACE, MD.						25a. REC'D BY REGISTRAR NOV 21 1967		25b. REGISTRAR'S SIGNATURE J. H. Judge			

FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

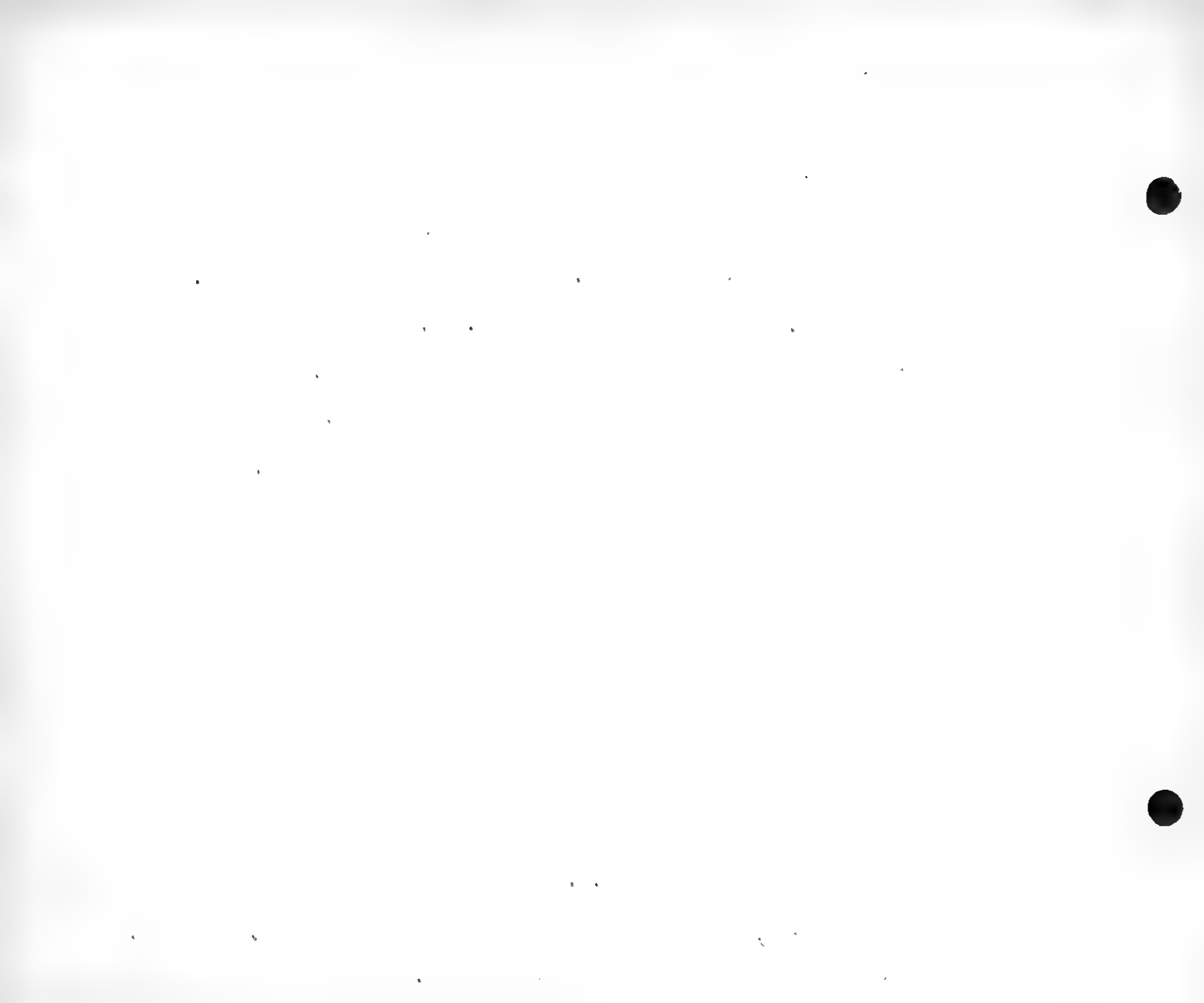
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived f institution Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> ✓	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Harre de Grace</u>		c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>
d NAME OF HOSPITAL OR INSTITUTION (f not in hosp to, g ve street address) <u>Harford Memorial Hospital</u>		d STREET ADDRESS <u>Elm Street</u>	e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Roger</u> Middle <u>J.</u> Last <u>Gilley</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Can.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 23, 1956</u>
9 AGE (In years ost birthday) <u>11</u> yrs		10 UNDER 1 YEAR Months <u>11</u> Days <u>25</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11 BIRTHPLACE (State or fore:gn country) <u>Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Earl Gilley</u>	
14 MOTHER'S MAIDEN NAME <u>Betty H. Martin</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT <u>Earl Gilley, Perryville, Maryland.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GS W Chest</u> 9190 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brother Pleasing Gun + it went off</u>			
19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Brother Pleasing Gun + it went off</u>		20c TIME OF INJURY Month, Day Year <u>8:30 p.m. 11-25-67</u>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home form factory, street office bldg, etc) <u>Home</u>	
20f (City or town) (County) (State) <u>Perryville Cecil Md.</u>		21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <u>11-26-67</u>		23a BURL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b DATE THEREOF <u>11-26-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>	
23d LOCATION (City or Town) (County) (State) <u>Colona, Maryland.</u>		24 FUNERAL DIRECTOR <u>Lee H. Patterson & Son, Perryville, Maryland.</u>	
25a REC'D BY REGISTRAR <u>NOV 28 1967</u>		25b REGISTRAR'S SIGNATURE <u>-----</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <u>3 1/2 weeks</u>		d. STREET ADDRESS <u>215 Fulford Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home - Harford Co</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>MONROE</u> Last <u>Grove</u>		4 DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7-MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-4-92</u>
9 AGE (In years last birthday) <u>75</u> yrs		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Monroe</u>		14. MOTHER'S MAIDEN NAME <u>Mercy Norris</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>220-44-6180</u>	
17. INFORMANT (Name, address, and relationship to deceased) <u>Self - Harry St.A. O'Neill</u>		Address <u>1 Wall Street</u> <u>Bel Air, Md. 21014</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Osteoarthritis - Osteoporosis</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> , 19 <u>67</u> , to <u>11/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>67</u> , and that death occurred at <u>4</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Sybil P.D.</u>		22b. DATE SIGNED <u>11/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. GRIGOLEIT</u>		22d ADDRESS <u>HARVEY De Grace MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 28, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford Co., Md. 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>W. Broadway & Williams St.</u> <u>Bel Air, Maryland 21014</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 29 1967</u>	



15448

CERTIFICATE OF DEATH

15448

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARTFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN TB <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARTFORD Memorial Hospital</u>		e. STREET ADDRESS <u>Concord Cove Apts.</u>	
3. NAME OF DECEASED (Type or print) <u>Douglas Alton</u> First <u>HALL</u> Middle Last		4 DATE OF DEATH <u>November 17</u> 19 <u>67</u> Month Day Year	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11 BIRTHPLACE (County & State, or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Douglas Hall</u>		14. MOTHER'S MAIDEN NAME <u>Ann Paige Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>None</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>116X Prematurity</u> DUE TO (b) <u>1 day</u> DUE TO (c) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>67</u> , to <u>Nov 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 17</u> , 19 <u>67</u> , and that death occurred at <u>4:40</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yun</u>		22b. DATE SIGNED <u>11/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>		22d. ADDRESS <u>HAURE DE GRACE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kuthuran</u>	23d. LOCATION (City or town) (County) (State) <u>Chesapeake, MD</u>
24. FUNERAL DIRECTOR <u>Funeral Home, Haure de Grace, Md</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loppa Towne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>206 Duryea Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Leonard</u> Last <u>Huebscher</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	9. AGE (In years last birthday) <u>65</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Huebscher Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Omerick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-03-5344</u>	
17. INFORMANT <u>Alma L. Huebscher</u>		Address <u>206 Duryea Dr. Loppa Towne Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Entricula r fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Extensive posterolateral myocardial infarction</u> DUE TO (c) <u>Posterior Coronary thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Insipidus</u>			19. WAS A TAPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18, 1967</u> to <u>11/18, 1967</u> , that (I) (we) lost the deceased alive on <u>11/18, 1967</u> , and that death occurred at <u>9:45 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loe, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/18/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loe, M.D.</u>		22d. ADDRESS <u>Harre-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem Stittz Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Rock R.D.3, Pa.</u>
24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	25a. REC'D BY REGISTRAR DATE <u>NOV 24 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Orlando Judge</u>	



15648

CERTIFICATE OF DEATH

15647

1 PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before adm ssion) a. STATE Md		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Citizens Nursing Home		d. STREET ADDRESS Route 1, Fox Road Box 269		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Rosa Jensen		4 DATE OF DEATH Nov. 18 19 67			
5 SEX F	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-10-10	9 AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Day/Mem - Hoof		11 BIRTHPLACE (County & State or foreign country) Denmark	
13. FATHER'S NAME Anders Larson		14. MOTHER'S MAIDEN NAME Anna Maria Van Couvern			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-40-8106		17. INFORMANT Elin J. Miller Address Fort Road Harford Co Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Bronchogenic Carcinoma DUE TO (b) (c) INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. , 19 67 , to 11-18 , 19 67 , that (I) (we) lost saw the deceased alive on 11-16 19 67 , and that death occurred at 11-16 M, from causes and on the date stated above.					
22a. SIGNATURE [Signature]		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-20-67	
22c. PHYSICIAN'S NAME (Type) [Signature]		22d. ADDRESS [Signature]			
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/21/67		23b. DATE THEREOF 11/21/67		23c. NAME OF CEMETERY OR CREMATORY Crest Hill	
23d. LOCATION (City or Town) Havre de Grace Md		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR [Signature]		ADDRESS [Signature]		25a. REC'D BY REGISTRAR DATE NOV 22 1967	
				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15649

11-12-67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Citizens Nursing Home Market St.</i>		d. STREET ADDRESS <i>1437 Stonewood Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <i>Mabel</i> Middle <i>A. Leimkuhler</i> Last		4. DATE OF DEATH Month <i>November</i> Day <i>17</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/26/1886</i>
9 AGE (In years last birthday) <i>81</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Eugene E. Peake</i>		14. MOTHER'S MAIDEN NAME <i>? Sword</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Eugene Leimkuhler</i>		Address <i>7 Sherwood Rd. Annapolis</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Conjunctive Heart Failure</i> DUE TO (b) <i>Pneumonia</i> DUE TO (c) <i>Pleural effusion - etiology undetermined</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>Charles J. Foley Jr.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Charles J. Foley Jr.</i>		22d. ADDRESS <i>Havre de Grace, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11/13/1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>	23d. LOCATION (City or town) (County) (State) <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR <i>John A. Moran Inc. 3000 E. Baltimore Street</i>		25a. REC'D BY REGISTRAR <i>NOV 14 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

CERTIFICATE OF DEATH

149

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>		e. STREET ADDRESS <u>Box 167</u>	
3 NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Lewis</u> Middle Last		4 DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>AUG 15, 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months <u>11</u> Days <u>30</u> Hours <u>11</u> Min <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MECHANIC</u>	
11 BIRTHPLACE (County & State or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW II</u>		16 SOCIAL SECURITY NO <u>218-28-2135</u>	
17 INFORMANT <u>RUTH C. LEWIS, DARLINGTON, MD.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY - ACUTE</u> DUE TO (b) <u>ADAMS STOKES SYNDROME</u> DUE TO (c) <u>CORONARY ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>14 hr</u> <u>54 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> , 19 <u>60</u> to <u>Nov 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 20</u> , 19 <u>67</u> , and that death occurred at <u>9 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips MD</u>		22b. DATE SIGNED <u>11/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>DARLINGTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 24, 1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>	23d. LOCATION (City or Town) (County) (State) <u>DARLINGTON, MD.</u>
24. FUNERAL DIRECTOR <u>John A. Ashkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>W. L. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15450 Item #2d filr # 5 12/1/67 ph

CERTIFICATE OF DEATH

15450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 5. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase</u> c LENGTH OF STAY IN 1b <u>3 yrs.</u>		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Baltimore</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase Md.</u>	
3 NAME OF DECEASED (Type or print) <u>Anna Virginia Maiton</u> First Middle Last 4 DATE OF DEATH <u>11/25/67</u> Month Day Year		5 SEX <u>Female</u> 6 COLOR OR RACE <u>White</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <u>1/22/1869</u> 9 AGE (In years last birthday) <u>98</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Harold Chase</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>J. Patrick Maiton</u>		14 MOTHER'S MAIDEN NAME <u>Barbara Burkett</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>none</u>	
17 INFORMANT <u>St. Johns Bayers</u> <u>A.B. Maiton</u> <u>Harold Chase Md</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>4221</u> DUE TO (b) <u>A.S.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Blood dyscrasia & thrombocytopenia etiology?</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 11</u> , 19 <u>64</u> to <u>Nov 28</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/25</u> , 19 <u>67</u> and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Edward C. Loo</u> M.D.		22b DATE SIGNED <u>11/25/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d ADDRESS <u>Harold Chase, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>11/29/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		23d LOCATION (City or Town) (County) (State) <u>Abingdon Md.</u>	
24 FUNERAL DIRECTOR <u>Burroughs & Son</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE		DATE <u>NOV 28 1967</u>	

CERTIFICATE OF DEATH

15452

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c LENGTH OF STAY IN lb 10 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d STREET ADDRESS R.D. 1, Box 389	
3 NAME OF DECEASED (Type or print) First JAMES Middle FREDDIE Last McCOMMONS		4. DATE OF DEATH Month November Day 19 Year 1967	
5 SEX Male	6. COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1870
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11 BIRTHPLACE (County & State, or foreign country) Harford County, Maryland
13. FATHER'S NAME James McCommons		14. MOTHER'S MAIDEN NAME Martha Bunce	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-36-2809	17 INFORMANT Mrs. Mary Siebert, Rd. 1, Aberdeen, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 177X generalized carcinoma of prostate DUE TO (b) carcinoma of prostate DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 mos ~ 5-1/2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) congestive heart failure			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 9 , 19 67 , to Nov. 19 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 19 , 19 67 , and that death occurred at 6:15 PM , from causes and on the date stated above.			
22a. SIGNATURE B. J. Plunkett, Jr.		22b. DATE SIGNED 11-20-67	
22c. PHYSICIAN'S NAME (Type) B. J. Plunkett, Jr. M.D.		22d ADDRESS 617 W. Bel Air, Ave. Aberdeen, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 22 Nov. 67	23c NAME OF CEMETERY OR CREMATORY Rack Run Cemetery	23d. LOCATION (City or Town) (County) (State) Havre de Grace (Harford) Md.
24. FUNERAL DIRECTOR Walter Macomber Jr.		25a. REC'D BY REGISTRAR NOV 24 1967	
Tarring Funeral Home, Aberdeen, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>9 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		d. STREET ADDRESS <u>Rt #1. Box 83a</u>	
3 NAME OF DECEASED (Type or print) <u>Nelson Augustus McVey</u>		4 DATE OF DEATH <u>11 16 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>October 21, 1877</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H McVey</u>		14 MOTHER'S MAIDEN NAME <u>Mary Elizabeth Bailey</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>217-54-8313</u>	
17 INFORMANT <u>Mrs. Robert Payne, Churchville, Md.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Failure</u> DUE TO (c) <u>Pulmonary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>weeks</u> <u>days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture Left Hip</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-16, 1967</u> to <u>11-16, 1967</u> that (I) (we) last saw the deceased alive on <u>11-16, 1967</u> , and that death occurred at <u>4:50 P</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Leyte-Vidal</u>		22b DATE SIGNED <u>17 Nov. 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Sanlago Leyte-Vidal, M.D.</u>		22d ADDRESS <u>Aberdeen, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-19-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Aberdeen, Maryland</u>
24. FUNERAL DIRECTOR <u>Tarring Funeral Home, Aberdeen, Maryland</u>		25a REC'D BY REGISTRAR <u>NOV 20 1967</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15453

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md</u> b COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c LENGTH OF STAY IN 1b <u>11 days</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d STREET ADDRESS <u>620 S. MAIN Street</u>	
3 NAME OF DECEASED (Type or print) <u>FRANK Elwood MONKS</u>		4 DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>February 14, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver - Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bus Transportation</u>	9 AGE (In years last birthday) <u>74</u> yes
11 BIRTHPLACE (County & State, or foreign country) <u>Hartford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Archer Monks</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Phelps</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW #1</u>		16 SOCIAL SECURITY NO. <u>215-01-3990</u>	
17 INFORMANT (with) <u>838-3355</u> Address <u>620 South Main Street</u> <u>Mrs Laura A. Monks</u> <u>Bel Air, Maryland 21014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Bleeding obstruction</u> DUE TO (c) <u>Malignant Ca of Colon</u>			INTERVAL BETWEEN ONSET AND DEATH. <u>5 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>11-18, 1967</u> to <u>11-28, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-28, 1967</u> , and that death occurred at <u>6 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>W. Grig. Lett MD</u>		22b. DATE SIGNED <u>11/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. GRIGLETT</u>		22d. ADDRESS <u>HAVRE DE GRACE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 1, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Hartford Co., Md. 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St.</u> <u>Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 4 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

CERTIFICATE OF DEATH

34

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oden 10 n.</u>	
c. LENGTH OF STAY IN 1b <u>8 days</u>		d. STREET ADDRESS <u>P.O. Box 134</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert F. Moore</u>		4. DATE OF DEATH <u>11-5-1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 1, 1899</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>5</u> Hours <u>5</u> Min <u>1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>STEELWORKER (RET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>	
11. BIRTHPLACE (Country & State or foreign country) <u>VAN HOE, N. CAR</u>		12. C. T. ZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>YES JAN 6, 1941 1964</u>		16. SOCIAL SECURITY NO <u>213-09-1817</u>	
17. INFORMANT <u>Robert F. Moore</u>		Address <u>Harre-de-Grace, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive and arteriosclerotic</u> DUE TO (c) <u>Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Terminal Pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 20, 1967</u> to <u>Nov 5, 1967</u> that (I) (we) last saw the deceased alive on <u>Nov 5, 1967</u> and that death occurred at <u>Harre-de-Grace, Md.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/5/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>NOV 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TRULMAN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>STATESVILLE N. CAR.</u>
24. FUNERAL DIRECTOR <u>Charles Judge</u>		ADDRESS <u>530 WASHINGTON BLVD, LAUREL, MD.</u>	25a. REC'D BY REGISTRAR <u>NOV 15 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VII A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15455

15455

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL TOPPA</u>		c. LENGTH OF STAY IN 1b <u>8 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL TOPPA</u>		d. STREET ADDRESS <u>1003 PULASKI HIGHWAY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1003 PULASKI HIGHWAY</u>				d. STREET ADDRESS <u>1003 PULASKI HIGHWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>SIMON</u> First Middle Last <u>MOTOWYLAK</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-18-86</u>	9 AGE (In years last birthday) yrs <u>81</u>	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. U.S. GOVT</u>		10b KIND OF BUSINESS OR INDUSTRY <u>HARBOR</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. U.S. GOVT</u>				10b KIND OF BUSINESS OR INDUSTRY <u>HARBOR</u>		11 BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13 FATHER'S NAME <u>JOSEPH MOTOWYLAK</u>			
14 MOTHER'S MAIDEN NAME <u>ANNA CACHLA</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16 SOCIAL SECURITY NO. <u>111-01-3210</u>				17 INFORMANT Address <u>JULIA FROMLING TOPPA, MD.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4341 DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Congestive Heart Failure</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>57</u> , to _____, 19 _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D.				22b. DATE SIGNED <u>11/27/67</u>		22c. PHYSICIAN'S NAME (Type) <u>LOUIS KARNY</u>	
22d. ADDRESS <u>EDGEWOOD, MD</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>11-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. ROSE OF LIMA</u>		23d. LOCATION (City or Town) (County) (State) <u>CHESAPEARE CITY MD.</u>			
24 FUNERAL DIRECTOR <u>Robert G. PIPPIN FUNERAL HOME</u> ADDRESS <u>FLRTON, MD.</u>				25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15156

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill (Rural)</u>		c. LENGTH OF STAY IN 1b <u>Forest Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hess Road</u>		e. STREET ADDRESS <u>Griffiths Road</u>	
3 NAME OF DECEASED (Type or print) <u>Alexandras Orantzas</u>		4 DATE OF DEATH Month <u>November</u> , Day <u>27</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 21, 1912</u>
9 AGE (In years last birthday) <u>55</u> yrs		10 IF UNDER 1 YEAR Months <u>55</u> Days <u>27</u> Hours <u>11</u> Min <u>17</u>	
11a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11c. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Jonas Orantzas</u>		14 MOTHER'S MAIDEN NAME <u>Ona Griedrius</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>219-30-5784</u>	
17. INFORMANT (with) <u>838-5110</u> Address <u>Mrs. Veronika V. Orantzas Forest Hill Md. 21054</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BEL Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>BEL Air, Maryland Co, Maryland 21014</u>
24 FUNERAL DIRECTOR <u>Joseph William Foster</u>		25. REG'D BY REGISTRAR <u>NOV 29 1967</u>	
ADDRESS <u>W. Broadway & Williams St. BEL Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15459

CERTIFICATE OF DEATH

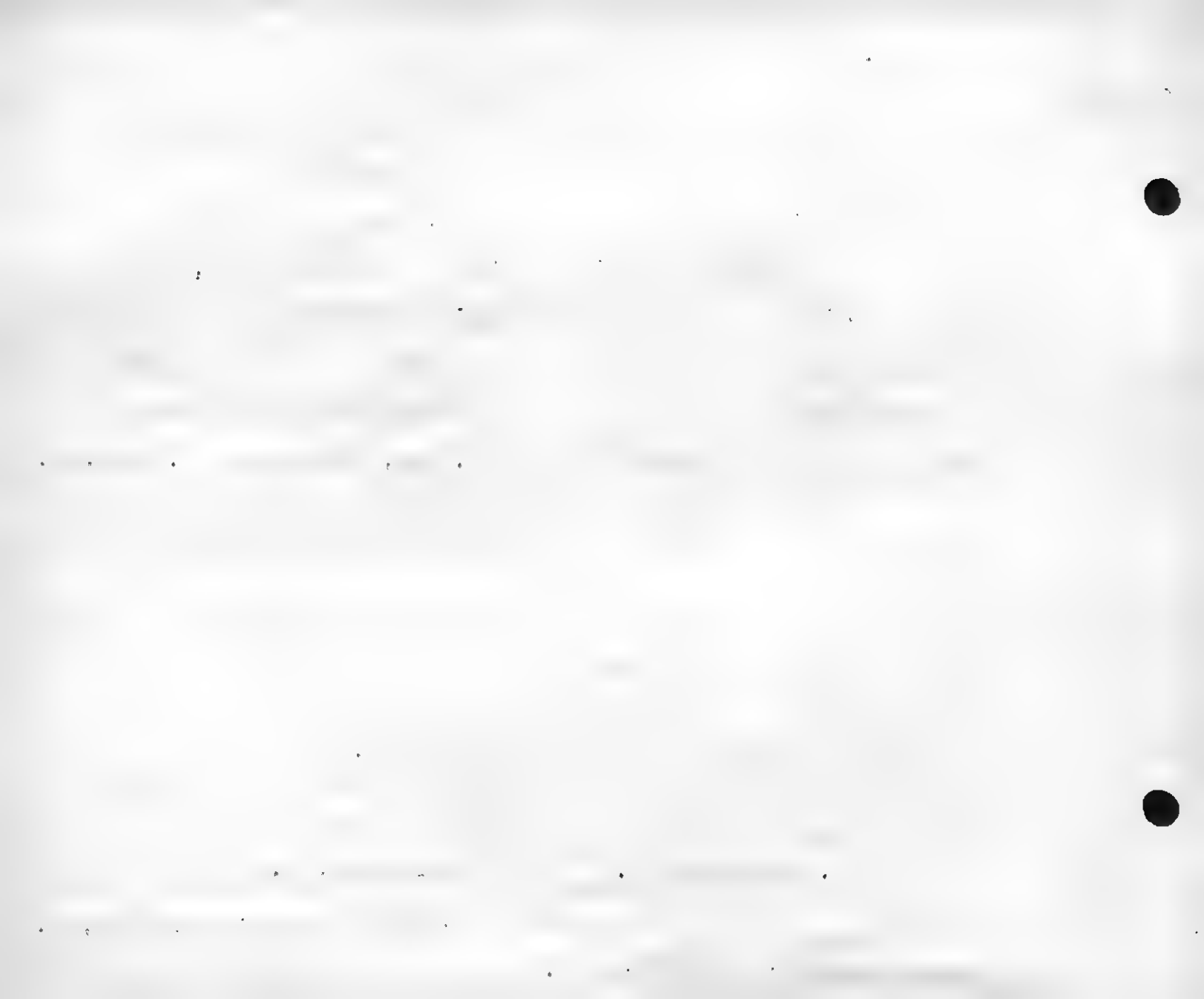
15-57

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RD# 1, Box 427		e. STREET ADDRESS RD #1, Box 427	
3 NAME OF DECEASED (Type or print) First MABEL Middle ADAIR Last PAGE		4 DATE OF DEATH Month Nov. Day 8th Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9th 1883
9. AGE (In years last birthday) yrs 84		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Anderson	
14. MOTHER'S MAIDEN NAME Mary Adair M. Kee		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-38-2417		17. INFORMANT Lee V. Page, 704 Old Joppa Rd. Joppa, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Arteriosclerotic CV Disease (c) 5 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1967 to Nov 7, 1967 , that (I) (we) lost saw the deceased alive on Nov 7, 1967 , and that death occurred at 6:00 AM , from causes and on the date stated above.			
22a. SIGNATURE J. Ralph Horky		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. Ralph Horky, MD.		22d. ADDRESS Churchville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/10/1967	23c. NAME OF CEMETERY OR CREMATORY Churchville Presbyterian	23d. LOCATION (City or Town) (County) (State) Churchville, Harford, Md.
24. FUNERAL DIRECTOR Tarring Funeral Home		25a. REC'D BY REGISTRAR Charles J. J...	
25b. REGISTRAR'S SIGNATURE Charles J. J...		DATE NOV 13 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15458

CERTIFICATE OF DEATH

15458

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. LENGTH OF STAY IN 1b 78 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street		d. STREET ADDRESS Main Street	
3 NAME OF DECEASED (Type or print) Anna Parry		4. DATE OF DEATH Month November Day 11 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1889
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (Country & State, or foreign country) Cardiff, Md.
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Parry	
14 MOTHER'S MAIDEN NAME Carrie Stull		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO.		17 INFORMANT Mrs. Carrie Bryson, Cardiff, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 4x101 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary sclerosis DUE TO (c) Arteriosclerosis C-V Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour o m. 19 p.m.	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 11/10/67 , 19 67 , to 11/11/67 , 19 67 , that (I) (we) last saw the deceased alive on 11/10/67 19 67 , and that death occurred at 4 A M, from causes and on the date stated above.	
22a SIGNATURE Josiah A. Hunt		22b DATE SIGNED Nov. 13, 1967	
22c PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.		22d ADDRESS Delta, Pa.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/14/67	
23c NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery		23d LOCATION (City or town) (County) (State) Delta, York Co., Pa.	
24 FUNERAL DIRECTOR John H. Harkins		25a REC'D BY REGISTRAR DATE NOV 14 1967	
25b REGISTRAR'S SIGNATURE W. L. ... Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE Maryland b COUNTY Harford	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bel Air		c LENGTH OF STAY IN b 1 1/2 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Main Street		e STREET ADDRESS 602 South Shamrock	
3 NAME OF DECEASED (Type or print) Otto Elmer Peterson		4 DATE OF DEATH Month November Day 13 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1884 June 20, 1885 9 AGE (In years lost birthday) 82 yrs
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Carpenter		10b KIND OF BUSINESS OR INDUSTRY Construction	
11 BIRTHPLACE (State or foreign country) New Windsor, Illinois		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew John Peterson		14 MOTHER'S MAIDEN NAME Emma C. Peterson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 503-12-7114-A	
17 INFORMANT (Son) 838-4408		602 S. Shamrock Mr. Kendall L. Peterson Bel Air, Md. 21014	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420i DUE TO ASCVD (long standing) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) ASCVD Long Standing			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (city town) (county) (State)
21 I certify that took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip W. Houtman M.D.		22. DATE SIGNED Nov. 13, 1967	
EXAMINER'S NAME (Type) Philip W. Houtman, M.D. 307 Hickory Ave, Bel Air, Md. 21014		23a LOCATION (city town) (county) (State) Denver, Colorado	
23b BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 17, 1967	23c NAME OF CEMETERY OR CREMATORY Fairmont Cemetery	
24 FUNERAL DIRECTOR Joseph William Foster		25a REC'D BY REGIS. RAR NOV 16 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

Joseph William Foster



CERTIFICATE OF DEATH

1-1-69

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		d. STREET ADDRESS <u>421 Baltimore Pike</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Edith Poe</u>		4. DATE OF DEATH Month Day Year <u>11 23 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1902</u>
9. AGE (In years last birthday) <u>75 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Franklin Welch</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Wayson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>218-01-1262</u>		17. INFORMANT (Nephew) 1-25-M-4-4280 Address <u>Mr. Norman S. Lightcap 10 East Golf Club Lane Pottsville, Pennsylvania 19301</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, left</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Arteriosclerosis (V. disease)</u> DUE TO (c) <u>6 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 16, 1967</u> , to <u>Nov 23, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Nov 23, 1967</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph W. Foster</u> M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22b. DATE SIGNED <u>11/23/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Joseph W. Foster, M.D.</u>		22d. ADDRESS <u>Churchville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	23b. DATE THEREOF <u>November 27, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Co. Maryland 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>John W. Edgar</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10261

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if inst. on Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Cecil</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford & Grace</u>		c LENGTH OF STAY IN 1b <u>D.O.H.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DoA Harford Memorial Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>April L Richmond</u>		4 DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 30 1965</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Daniel Arden Richmond</u>		14 MOTHER'S MAIDEN NAME <u>Joyce Ann Hardiman</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. A. SECURITY NO. <u>None</u>	
17 INFORMANT <u>James Hardiman</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Third Degree Burns Body</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A UPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Burned in Trailer Fire</u>	
20c TIME OF INJURY Month Day Year Hour <u>5:30 pm 11-8 1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Trailer</u>		20f (City or town) (County) (State) <u>Rising Sun Cecil Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		22 DATE SIGNED <u>11-8-67</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b DATE THEREOF <u>Nov 11, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem</u>	
23d LOCATION (City or Town) (County) (State) <u>Colona Cecil Md</u>		24 FUNERAL DIRECTOR <u>Wm. Rising Sun Md</u>	
25a REC'D BY REGISTRAR <u>Nov 13 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH REPORT

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15463

11-8-67

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arden-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daniel A Richmond Jr</u>		4. DATE OF DEATH <u>November 8 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Daniel Arden Richmond</u>		14. MOTHER'S MAIDEN NAME <u>Joyce Ann Hardiman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James Hardiman</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Third Degree Burns Body</u> 9160 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Burned in Trailer Fire</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:30 p.m. 11-8-67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>Home</u>
20f. (City or town) <u>Rising Sun</u> (County) <u>Cecil</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bo/Air</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem</u>		23d. LOCATION (City or town) <u>Colord Cecil Md</u>	
24. FUNERAL DIRECTOR <u>W B Mc Mullen</u> ADDRESS <u>Rising Sun, Md</u>		25a. REC'D BY REGISTRAR <u>Nov 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>John Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15464

10063

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) HAVRE DE GRACE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD MEMORIAL HOSP.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN d. STREET ADDRESS 427 BALTIMORE STREET		5. RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STERLING DUMAP SHEPPARD		4. DATE OF DEATH Month NOV Day 11 Year 1967			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 1942	9. AGE (In years last b. (day) 25 yrs	10. IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Worker American Cyanamid Co.		11b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Peter Jojner		14. MOTHER'S MAIDEN NAME Genevieve Sheppard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) VI/1961 to 1/1964		16. SOCIAL SECURITY NO. 212-40-7472		17. INFORMANT Mrs. Sandra Sheppard - Aberdeen, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE HEAD INJURIES, BROKEN NECK DUE TO (b) AUTO ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH INSTANT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) LOST CONTROL OF AUTO - RAN INTO PILE OF ROCKS			
20c. TIME OF INJURY Hour 4:55 a. m. Month NOV Day 11 Year 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STREET	
				20f. (City or town) HAVRE DE GRACE (County) HARFORD (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Philip W. Heuman		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED NOV 11, 1967	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 16, 1967		22c. NAME OF CEMETERY OR CREMATORY Union Methodist Cem.	
				22d. LOCATION (City, town, or county) Aberdeen (State) Harford Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR NOV 20 1967	
				24b. REGISTRAR'S SIGNATURE Thomas Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15465

15465

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Tarford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>HARFORD</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen - Rural</u>		c LENGTH OF STAY IN 1b <u>25 years</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN - Rural</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>		d STREET ADDRESS <u>Box 82A, R.D. #3</u>	
3 NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>WALTER</u> Last <u>SIEMIERSKI</u>		4 DATE OF DEATH Month <u>NOVEMBER</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 27, 1892</u>
9 AGE (In years last birthday) <u>75</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner-Op., Service Sta.</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Gasoline</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Balto Co., Md.</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Frank Siewierski</u>	
14 MOTHER'S MAIDEN NAME <u>Anna Ziegalski</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16 SOCIAL SECURITY NO. <u>213-14-5024A</u>		17 INFORMANT <u>Mrs. Madeline Francis, Montreal Drive, R.D. #1</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1</u> , 19 <u>62</u> , to <u>Nov. 4</u> , 19 <u>67</u> ; that (I) (we) lost saw the deceased alive on <u>Nov. 3</u> , 19 <u>67</u> , and that death occurred at <u>4</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Gerald C. Palmer</u>		22b. DATE SIGNED <u>11-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gerald C. Palmer</u>		22d. ADDRESS <u>Bel Air, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Nov. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Howard K. & Son, Abingdon, Md.</u>		25a REC'D BY REGISTRAR <u>Nov 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15105

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		d. STREET ADDRESS <u>257 Lewis Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>P.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1885</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Jufield, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Cesar Hunter</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>219-07-4254</u>	
17. INFORMANT <u>Mrs. Elijah Smith, Havre de Grace, Md.</u>		Address <u>257 Lewis St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> DUE TO <u>Hypertensive vasc. disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 4</u> , 1967, to <u>Nov 27</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov. 27</u> , 1967, and that death occurred at <u>2:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>L.I. Mezei</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L.I. Mezei M.D.</u>		22d. ADDRESS <u>601 S. Union Ave., Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, Hartford, Md.</u>
24. FUNERAL DIRECTOR <u>Otelia J. Bullock, Havre de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Jones</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		DATE <u>DEC 5 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

15166

1 PLACE OF DEATH a. COUNTY Harford		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 09-18- to 11/15/67 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Citizens Nursing Home		d. STREET ADDRESS 202 Sunnyside Dr. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last MAE ELIZA STINE		4 DATE OF DEATH Month Day Year Nov. 15 1967	
5 SEX F	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-5-85
9 AGE (In years last birthday) 82 yrs		11 BIRTHPLACE (County & State, or foreign country) Bradshaw, Balto. Co. Md.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY Home	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME John Akers (D)	
14 MOTHER'S MAIDEN NAME Alice Cullum (D)		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 218-52-2959-T		17. INFORMANT Address Mamie Miles, Aberdeen, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260x DUE TO Cor. heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Diabetes mellitus (c) years.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 18 19 67 to Nov. 15 19 67 that (I) (we) last saw the deceased alive on Nov. 15 19 67 , and that death occurred at 2:20 PM , from causes and on the date stated above			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 15 Nov. 1967	
22c. PHYSICIAN'S NAME (Type) I, Mezei		22d ADDRESS Havre de Grace, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 18 Nov. 67	23c NAME OF CEMETERY OR CREMATORY Harmony Presbyterian Cem.	23d LOCATION (City or Town) (County) (State) Darlington, Maryland
24. FUNERAL DIRECTOR Tarring Funeral Home,		25a. REC'D. BY REGISTRAR DATE NOV 20 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15468

CERTIFICATE OF DEATH

15107

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hayre de Grace c. LENGTH OF STAY IN 1b 8/22 to 11/28/67 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Citizens Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Md. b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville, R.R. 1, Box 90 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Zollie Greer Thompson		4. DATE OF DEATH Month Day Year Nov. 28 19 67	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/80
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 28 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State or foreign country) N. Carolina (Grassy Creek)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Greer (D)		14. MOTHER'S MAIDEN NAME Mary E. Pierce (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 215-07-3003		16. SOCIAL SECURITY NO. 215-07-3003	
17. INFORMANT Thelma T. Greenfield, Churchville, MD		18. ADDRESS Thelma T. Greenfield, Churchville, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Atherosclerosis of Vessels DUE TO (c) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 6 days 8 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 2, 19 67 to Nov. 28, 19 67 , that (I) (we) last saw the deceased alive on Nov 28 19 67 , and that death occurred at 4:13 PM from causes and on the date stated above.			
22a. SIGNATURE J. Ralph Horky		22b. DATE SIGNED Nov 29 1967	
22c. PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.		22d. ADDRESS Churchville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 Dec., 1967	
23c. NAME OF CEMETERY OR CREMATORY Smith Chapel Cemetery		23d. LOCATION (City or Town) (County) (State) Churchville, Maryland	
24. FUNERAL DIRECTOR Tarring Funeral Home		25a. REC'D BY REGISTRAR DEC 1 1967	
25b. REGISTRAR'S SIGNATURE John W. Waco			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 2013. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 395 12-1-67 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Res. change before admission) a STATE Maryland b COUNTY Harford	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c LENGTH OF STAY IN 1b 25 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e STREET ADDRESS Grafton Shop Road	
3 NAME OF DECEASED (Type or print) First Middle Last Anna Isadora Treadwell		4 DATE OF DEATH Month Day Year November 20, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH February 28, 1880
9 AGE (In years last birthday) 87 yrs		10 UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Homemaker	
11 BIRTHPLACE (State or foreign country) Harford Co., Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME James Poole		14 MOTHER'S MAIDEN NAME Louisa Heusler	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give war or dates of serv. etc.) No		16 SOCIAL SECURITY NO 218-52-3478	
17 INFORMANT (Son) 838-4058		Address P.O. Box #266 Bel Air, Md. 21014	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 9047 Fracture Femur DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic EV Disease		19 WA. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 8, if applicable) Fell	
20c TIME OF INJURY Month Day Year Hour a.m. pm 10-27 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Harf. Conv. Home		20f (City or town) (County) (State) Bel Air Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <input checked="" type="checkbox"/> Specimen <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPTLY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D. Bel Air, Md.		Address (Street city town or county) Bel Air Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 22, 1967	
23c NAME OF CEMETERY OR CREMATORY St. Ignatius Cath. Ch. Cem.		23d LOCATION (city or town, county, state) Hickory, Harf. Co., Md.	
24 FUNERAL DIRECTOR W. Broadway & Williams St. Bel Air, Maryland 21014		25a REC'D BY REG. TRAR Nov 24 1967	
25b REG. TRAR'S SIGNATURE Charles Judge		25c DATE Nov. 21, 1967	

Joseph William Foster

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CERTIFICATE OF DEATH

10-139

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvre d. Grace</u>		c. LENGTH OF STAY IN 1b <u>1/10/40/11/27/67</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		d. STREET ADDRESS <u>24 Penna. Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>T.</u> Last <u>Turner</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/81</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thorn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>218-54-0039</u>	
17. INFORMANT (Last) <u>Mr. Robert N. Turner</u>		Address <u>24 Pennsylvania Ave. Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pneumonia -</u> DUE TO <u>A-S-E-V-P</u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renovated arches</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u> </u> , to <u>11-26</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>11-26</u> , 19 <u> </u> , and that death occurred at <u> </u> M, from causes and on the date stated above			
22a. SIGNATURE <u>John D. Yarn</u>		22b. DATE SIGNED <u>Nov. 27, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YARN</u>		22d. ADDRESS <u>HARVREDE GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cath. Ch. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Low Green, Balto. Co., Md.</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>	
ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY in lb <u>13 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Prospect Rd - RO 1</u>	
3 NAME OF DECEASED (Type or print) <u>Kathleen Elizabeth Watson</u>		4 DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31 1954</u>
9. AGE (In years last birthday) <u>13</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (County & State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Granville Watson</u>	
14. MOTHER'S MAIDEN NAME <u>Ruth Lang</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Granville Watson</u> Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Coma (Failure).</u> 5810 DUE TO (b) <u>Hepatic cirrhosis (Post neontic).</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypoproteinnemia - Splenomegaly - Cerebral Edema.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> , 19 <u>67</u> , to <u>11-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-6</u> , 19 <u>67</u> , and that death occurred at <u>3:30AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Alonso Gomez</u>		22b. DATE SIGNED <u>11/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alonso Gomez</u>		22d. ADDRESS <u>419 S. Union Ave. Harre de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holly Hill Memorial Gardens Balto. Co., Md.</u>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <u>Brzezinski Funeral Home</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15472

CERTIFICATE OF DEATH

15471

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>INA</u>		4. DATE OF DEATH <u>November 19, 1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 10, 1905</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>541 Bonnie Davis</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) _____ DUE TO (c) <u>Hypertensive - Arteriosclerotic Heart disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15, 1967</u> to <u>Nov. 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 19, 1967</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>11/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>569 Revolution St. Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Unk</u>		23b. DATE THEREOF <u>11/25/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Unk</u>		23d. LOCATION (City or town) (County) (State) <u>Unk</u>	
24. FUNERAL DIRECTOR <u>Unk</u>		25a. REC'D BY REGISTRAR <u>Unk</u>	
25b. REGISTRAR'S SIGNATURE <u>Unk</u>		DATE <u>NOV 22 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use as the burial-transit permit. The original of this certificate should be filed with the State Dept. of Health prior to burial, cremation or other disposition of the body.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>HANFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HANFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Horse & Grace DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dort Hanford Memorial Hospital</u>		d. STREET ADDRESS <u>Jordan's App'ts</u>	
3. NAME OF DECEASED (Type or print) <u>MIFFLIN H WILDE</u>		4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG/8/1897</u>
9. AGE (In years lost birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MARTINSBURG, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Rodger Wild</u>		14. MOTHER'S MAIDEN NAME <u>ANNETTA Hedges</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>UNK</u>	
17. INFORMANT <u>JULIAN WILDE 1404 W. King ST.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel A. S. M</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-15-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>11/16/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>MARTINSBURG, W. Va.</u>
24. FUNERAL DIRECTOR <u>Cunningham Son Hardware & More, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 22 1967</u>	

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